**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

TEXAS ORTHOPEDICS SURGERY CENTER
4700 SETON CENTER PARKWAY 100
AUSTIN TX 78759

**Respondent Name**
NEW HAMPSHIRE INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 19

**MFDR Tracking Number**
M4-11-0997-01

**MFDR Date Received**
NOVEMBER 22, 2010

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary dated November 22, 2010:** "Not paid at DWC fee amount."

**Requestor's Supplemental Position Summary dated January 20, 2011:** "We did receive the additional payment of $1102.92 and the interest that was paid for CPT 29807. Unfortunately we can not withdraw our dispute at this time because we also requested separate payment for the surgical implants as allowed by the Texas fee schedule. HCPCS code L8699 billed for the four sututre anchors that were used should also be paid at the invoiced cost of the anchors plus 10% ($1860.00 + $186.00 = $2046.00). We are still due $2046.00 on this claim. Please have this remaining payment issued and then we will withdraw our dispute."

**Amount in Dispute:** $2,046.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary dated December 17, 2010:** "Please be advise that we did received this MDR & we resubmitted to our audit dept to review – however at this time we do not have the outcome once this information has been updated – we will be advising everyone."

**Response Submitted by:** Gallagher Bassett Services, Inc.

**Respondent's Position Summary dated December 27, 2010:** "Please find the attached information showing that additional money ahs been issued onthis bill in the amount of $1102.92 plus interest in the amount of $17.34 once this amount has been received we request that the MDR be with drawn."

**Response Submitted by:** Gallagher Bassett Services, Inc.

**Respondent's Position Summary dated March 23, 2012:** "The carrier is in receipt of a request for copies of contracts between the informal/voluntary network and the carrier, and between the informal/voluntary network and the provider. The carrier will use best efforts to secure copies of the requested contracts, and will provide them to the Medical Review Division as soon as possible."

**Response Submitted by:** Flahive, Ogden & Latson

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 12, 2010 | HCPCS L8699-SG (X4) | $2,046.00 | $2,046.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 18-(189) Not otherwise classified or unlisted procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.
   - 18- (189) This line was included in the reconsideration of ths previously reviewed bill.
   - 16-Claim/Service lacks information which is needed for adjudication. Additional information is supplies using remittance advice remarks code.

**Issues**

1. Is the requestor entitled to reimbursement?

**Findings**

1. According to the explanation of benefits, the respondent denied reimbursement for HCPCS L8699 based upon reason code "16." A review of the submitted documentation finds an Arthrex Invoice; therefore, the respondent's denial is not supported.

   28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   28 Texas Administrative Code §134.402(f)(1)(B) states "if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of:

   (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission."

   A review of the submitted medical bill supports the requestor's position that separate reimbursement for the implantable was made.

   The Arthrex Suture Anchor invoice indicates the cost for the implantable was $465.00 each. The requestor billed for four; therefore, 4 X $465.00 = $1860.00. Per 28 Texas Administrative Code §134.402(f)(1)(B), to determine the MAR for the implantable it is cost + 10% = $2,046.00. As a result, $2,046.00 is recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $2,046.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,046.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | | |
|---|---|---|
| | | 2/1/2013 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.